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County health organization in the United States

New York

1915

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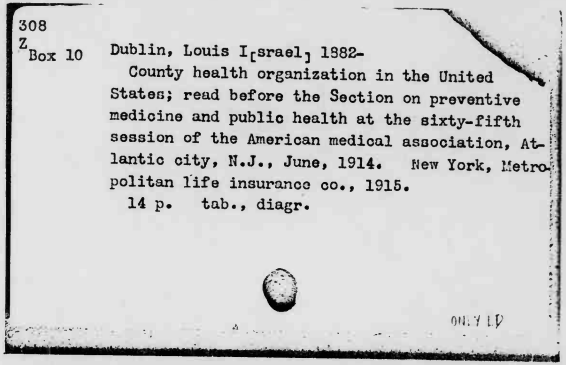
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County health organization in the United States; read before the Section on preventive medicine and public health at the sixty-fifth session of the American medical association, Atlantic city, N.J., June, 1914. New York, Metropolitan life insurance co., 1915.
14 p. tab., diagr.

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TECHNICAL MICROFORM DATA

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County Health Organization in the United States

Read before the Section on Preventive Medicine and Public Health at the Sixty-Fifth Annual Session of the American Medical Association, Atlantic City, N. J., June, 1914

BY
LOUIS I. DUBLIN, PH.D., Statistician
Metropolitan Life Insurance Company, New York
1915

13 Sept. 1915. MS

County Health Organization in the United States*

LOUIS I. DUBLIN, PH.D.
Statistician, Metropolitan Life Insurance Company
NEW YORK

County health organization in the United States is especially significant in relation to the problems of rural sanitation. The campaigns of the last three decades have resulted in the establishment of active and fairly efficient offices of health in the cities. The concentration of people into the cities and the larger financial resources of these communities have made such service absolutely necessary and possible. In the country, on the other hand, the need for efficient health work is apparently not so imminent, funds are not so available, and as a result, this phase of community work has been slightly developed. With few exceptions, there is very little health control in the rural sections of the United States. It is the purpose of this paper to suggest a system of county health organization which, it is believed, will help to co-ordinate the several health functions of the state and to lay firmer foundations for the control of rural sanitation.

COMPARATIVE DECLINE IN URBAN AND RURAL MORTALITY
(IN REGISTRATION STATES AS CONSTITUTED IN 1900)
FROM ALL CAUSES

	Death Rates per 1,000 of Population						Decline in Death Rate '12 from '00	
	1900	1905	1910	1912	Av'ge '01-'05	Av'ge '05-'09	Actual	Pct.
Registration states	17.2	15.9	15.6	14.6	15.9	15.5	2.6	15.1
Rural part of registration states	15.2	14.4	14.7	13.9	14.1	14.2	1.3	8.6
Cities in registration states	18.9	17.1	16.2	14.9	17.4	16.4	4.0	21.2

A few statistics will help to a clearer understanding of our subject. The death rate has materially declined. In 1900, it

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Reprinted from The Journal of the American Medical Association Nov. 14, 1914 Vol. LXIII, pp. 1739-1743.

was 17.2 per thousand living in the registration states and in 1912, the rate for the same states was only 14.6, a reduction of 2.6 per thousand, or 15.1 per cent. This decline in mortality, however, was much more pronounced in the cities, where the rate fell 21.2 per cent. in the twelve years under discussion, as against a decline of only 8.6 per cent. in the country districts. These figures (given in the table and chart) do not portray an accidental condition, but are descriptive of a pronounced tendency in American mortality in the urban and rural sections of the country.

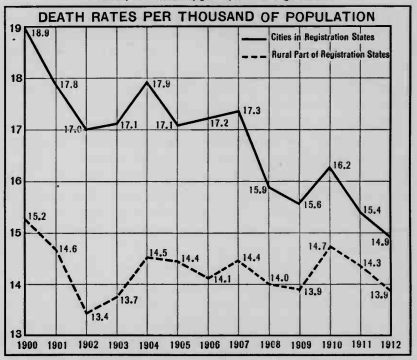
These death rates, to be sure, do not contain any allowance for the differences in age and sex composition of the population in the rural and urban districts. But the importance of this fact must not be overemphasized, for when the rates are standardized, the changes will be found to be slight and will scarcely affect the comparative rates of decline. There are other and more important elements of population composition than age and sex that should be considered in this connection. The country districts are the homes of the native stock of America, while the cities receive annually hordes of emigrants from Europe, whose mortality is and has been for years much higher than that of our American stock. In like manner, the colored race with its high mortality rate is almost twice as largely represented in the cities of the registration states as in the rural sections. If, therefore, a complete standardization were made of the death rates presented in the chart we should find that the small advantage still in favor of the rural area in 1912 would be still further reduced if not entirely obliterated.

The explanation of the conditions we have just observed in the death rates of the city and the country lies largely, I think, in the differences in the efficiency of their health services. Yet it is in the rural section of the country that more than one-half of the people of the United States still live. In 1910, 53.7 per cent. of our population were located in centers with populations under 2,500. In spite of the growth of our cities, America is still, and by necessity must long remain, largely rural in character. It is to the country-side, therefore, that we must turn for many years for our most profitable life conservation work. No greater opportunity awaits the American Medical Association and other bodies interested in improving health conditions than to concentrate their energies to this section of the country and

to accomplish, if only in a limited manner, what has been done in the American cities.

The key to the solution of the problem of rural hygiene lies in the development of efficient county health organizations in the United States. In most states, the chief unit of local government is the county. There are 2,953 counties in the United States. The typical county is about 600 square miles in

A Comparison of Urban and Rural Mortality in the United States.
(Registration States as Constituted in 1900.)
Deaths, All Causes, per 1,000 of Population.



area with a population of about 20,000. Five-sixths of these counties are rural in character; fully 10 per cent. have no incorporated places; and about half contain towns with less than 2,500 people. The American county, however, has not as yet been aroused to the fact that it has distinct health functions to perform and that it is the only governmental unit that can properly and efficiently perform such functions. The county health officer should be the most important single factor in conserving American public health, but is practically the weakest link in our entire health system.

To obtain a more intimate view of county health organization in the United States, a questionnaire was sent by the Statistical Bureau of the Metropolitan Life Insurance Company to the executive health officers of all the states. We inquired into the provisions of the state health laws; into the organization of the departments; whether there were any county health officers and whether they were full-time officials; how these men were compensated; the amount of their compensation; and to whom they were responsible. Finally, we inquired into the need for full-time county health officers in the several states.

From our replies it was at once evident that we were concerned with a vital question. The answers were usually complete, clear and to the point and indicated that the subject of our inquiry was in many states the chief concern of the health authorities. The following is a brief summary of our replies:

Health administration is organized on the county plan in thirty-one states out of the forty-one that replied. Yet only five had arranged for full-time county health officers in any of their counties. These were Oregon and Washington, which have one full-time county health officer each; Colorado and Florida, which have two each, and North Carolina, which has eleven. In the other states, county health officers are part-time officials, if they exist at all.

In most states the compensation of the county health officers is determined by the local county commissioners or supervisors. In Louisiana, health officers are paid by the police jury of the parish and in Missouri by the county court. The county health officers of Florida are the only ones reported to be on the pay-roll of the State Board of Health. From all replies, however, we could infer that these health workers received entirely inadequate compensation. In many cases $100 a year was the total salary paid. In one state, fifty-six out of one hundred health officers received less than $200 annually, and this state has recently made considerable progress in its provision for county health service.

The county health officers of more than one-third of the states are responsible to local authorities only. Training in public health and sanitation is not a prerequisite for office. There is little, if any, provision for laboratory work. Tenure of

office is insecure and the machinery is political rather than scientific.

The one encouraging note in our replies was the almost unanimous demand for full-time county health officers. In this connection, the health executive of one of our Eastern states expresses the opinions of almost all of our correspondents when he says: "Yes. We feel the need for full-time county health service every day—all day."

We may, therefore, conclude from these answers to our several questions that full-time county health officers are an absolute necessity in most of our states; that very few such officers exist; that they are insufficiently paid; that responsibility to the centralized authority is lacking, and that county health work is only too often intimately connected with local politics. The present system of county health administration in the United States is inefficient and not conducive to the public welfare. The health officer of a large Western state aptly struck off the whole situation when he said: "The present system is not efficient and never can be."

What then is the solution to the problem presented by county health administration in the United States? It must be obvious that no system will be equally applicable to all the states. A plan that is practicable in New York may very well prove too expensive for a number of our Western or Southern states. Local conditions, both geographical and economic, will largely determine the details of organization. It is agreed, however, that certain fundamental considerations apply equally to all the states which have extensive rural populations, the local control of which is on the county plan. I propose to review briefly some of these requirements.

1. The county health organization of a state must be an integral part of the state health administration and be responsible to it. Public health protection is primarily a state function. The county health officer and the county board, whenever there is one, should, therefore, hold themselves in readiness to enforce orders from the state department. They should, moreover, be subject to removal by the state department for cause. The state, on its part, however, must recognize this dependence of the local organization through state subsidies to help cover the necessary expenditures for county health work.

2. The county health officer must be a full-time official. He must be one whose sole interest is in the community, to the exclusion of private interest, be it his own or that of private individuals or groups. We all know too well how often the part-time health officer who has a private practice to maintain must choose between the performance of public duty and the loss of his practice. This situation should not arise. He should never find it necessary to compete with those whom it is is his duty to supervise.

3. The county health officer should be trained in the science of sanitation and public health. Most practicing physicians are not well enough equipped to administer a progressive health office. The protection of the public health, as now conceived, is a science with its own data and formulas. The larger medical schools, such as those at Harvard and at the University of Michigan, for example, have organized special postgraduate courses leading to the degree of Doctor of Public Health. It will be a great day in American public health affairs when the medical officers will, as a class, qualify by study in such postgraduate courses.

4. The tenure of office of the health officer should be co-extensive with his efficient service. The successful health officer is made, not born. With a proper background of training, each year of added experience makes him a more useful servant of the state. The health officer should, therefore, be assured of a continuous tenure of office. He should in no way be a pawn in the political game. A period of six to eight years has been suggested as a sufficient term. Health officers who have made good should then be considered for reappointment, although the state may reserve the right to dismiss in shorter time those who are incompetent or neglectful of their duties.

In view of these requirements, it should hardly be necessary to point out that county health officers must be reasonably compensated for their services. Surely, if full time is required, the compensation must be sufficient to attract and to keep good men in the service without inflicting hardships upon them or their families. It is folly to set high standards and to make them impossible of attainment because of inadequate compensation or uncertainty of tenure. Salaries must be adequate to attract able men and to maintain them in a state of comfort consistent with their important duties.

Permit me to point out more definitely the character of the return that awaits the states on their investment in full-time county health officers. In spite of all our preconceived ideas as to the healthfulness of the country, the rural sections suffer severely from the ravages of tuberculosis. Such typically rural states as Kentucky and North Carolina (using these as examples) suffer a death rate from tuberculosis higher than for the registration states taken as a whole, and higher than that for the registration cities. It would be the first duty of a full-time health officer to address himself to the tuberculosis problem of his rural communities.

The typhoid problem is equally urgent. In 1911 the death rate from this disease was 22.2 per hundred thousand in the rural section as against 18.6 in the cities of the registration states. These figures in themselves clearly indicate the many sanitary dangers incident to life in the country. Typhoid fever is always, to the health engineer, an unerring signal directing him toward polluted water supplies, infected food products and unsupervised typhoid carriers. These are a constant menace to the entire state through their effect on milk and other food supplies. All of these sources of typhoid infection, including the disposal of dangerous waste products, lend themselves to the concerted efforts of modern sanitary science. Indeed, no disease has shown such a ready response to control as this preventable filth disease. The full-time health officer, supported enthusiastically by his community, would, in the course of his first administration, earn many times his cost in reducing sickness and death from this cause alone.

The full-time health officer would of course participate in other lines of health work. His influence would soon become evident in reduced rates of sickness and death for the other preventable diseases. In no one respect, however, would the services of the full-time officer be more constructive and remunerative to the community than his active participation in child hygiene. In the larger cities throughout the country, this phase of health administration is now permanently established. In the country, on the other hand, this work has not received any serious attention. Children are not so well housed or so well fed in the country as in the city, and school buildings are so poorly constructed that the children are often

exposed to conditions of weather and infection which bring about disease. It would be the function of the full-time county health officer to work in co-operation with the school authorities of his community and see that each child under his jurisdiction is examined for physical defects, at least once a year. If there were no better excuse than the need for some local authority to carry on intelligent and modern work in child hygiene, the states would be justified in appointing full-time county health officers for this purpose.

I need hardly point out to this audience the multitude of ways in which a well-trained and full-time county health officer would serve the state. I need only refer, in addition, to his influence on the vital statistics of his county. While no attempt should be made to burden him with the duties of local registration, his very presence, especially when fortified with an efficient laboratory, would serve to bring together most valuable records of the incidence of the communicable diseases, as well as to improve the registration of births and deaths.

In closing, may I suggest that the committee of your section which has been appointed to study this problem co-operate with the committee of the American Public Health Association with a view to formulating a model bill on the subject of county health administration? This task should not be a difficult one at this time. A number of states, including Kentucky, Maryland, Georgia and Kansas, have either passed laws for county health service or are actively engaged in studying the question. Other states, judging from the character of the answers to our questionnaire, are intensely interested. It should be possible, through conference and study, to determine what a county health bill should contain, and the endorsement of such a measure by this body at a subsequent meeting should be most helpful in placing it on the statute books of a number of states. I can conceive of no more promising field of work for the American Medical Association and especially for the Section on Preventive Medicine and Public Health.

ABSTRACT OF DISCUSSION

DR. WM. M. PERKINS, New Orleans: With the major argument of Dr. Dublin's paper I agree most heartily. The necessity for more definite organization is apparent. We are fighting the health campaign very much as an untrained mob would fight. That more definitely trained and equipped health-officials are needed is not disputed; nor that there is a necessity for permanent health-officials who thus would have some encouragement to undertake this special work. A health-official cannot be, as a rule, a practitioner at the same time. The health-officer is forced to come into such relations with the rest of the medical profession of the state that whenever political changes remove him he is put in a very bad position with regard to resuming practice. Therefore, men everywhere are hampered in their health-work by the necessity of making a living when the powers that be remove them. There is no more apparent root of evil in the health administration of the present than the constant political changes of health-officers and their domination by politics, and the insufficient guaranty of reward for faithful, persistent and trained effort. With regard to the organization of a proper health army, it has two aspects. One would be to enlarge the powers, duties and responsibilities of the county health-officer as far as possible; then the state health-officer could, to the limit of the state's powers, take up those things which the county health-officer was not empowered to handle, and could leave to the national health-service the matters beyond his own jurisdiction. I am strongly in favor of enlarging the present bureau of public health into a full set of furniture, making it a department, and giving the national health-service as many powers, duties and responsibilities as may be required. The state health-officer then would carry the work as far as he was able, and the local health-officials would be left as little as was necessary. Instead of putting the burden on the lower officials and building up, I think it should be put on the higher officials and built down. I doubt whether the wording of the phrase "full-time county health-officer" is exactly correct. "Full-time health-officer," by all means; but probably it would work out better if the scheme were adapted to a district rather than the county, as Dr. Dublin suggests. In Louisiana we recently tried the plan of suggesting a movement to redistrict the state, cutting out the forty-odd parish or county health-officers, and putting in a small body of full-time district health-officers. The very element of politics and the ambition that men have to hold positions of county health-officers—to which they give little time, little training, and from which they accomplish, many times, little result,—rendered these positions so attractive,

and of such honor and glory, that the incumbents fought vigorously not to lose them. With regard to Dr. Dublin's suggestion about legislation providing for and outling more definitely the duties of these local health-officers, we recently introduced a bill setting rather a high standard for these officers, giving them definite duties and responsibilities, and the bill was cheerfully killed in committee without much trouble to the state legislature. One or two local officials who feared that their deficiencies might be emphasized, came down with political pull, and it didn't take long to fix it. In every health conference that we have had in the last few weeks, one idea has been stressed all the way through: we need to educate the health-officers, the schoolteachers, the people and the lawmakers. In other words, the war that we wage, like most of our other campaigns for betterment, is a war against ignorance.

DR. W. H. SANDERS, Montgomery, Ala.: The question of securing adequate compensation to command the entire time of health-officers for the counties is being agitated in all of our states, and the outlook for the early future is growing brighter and brighter.

For eight or ten years, in my state, we have been working to this end. All we need to accomplish our object is to convince the people of the value of such an officer. Eight or ten years ago we secured a law laying down a minimum below which the authorities of a county could not go in fixing the salary of the county health-officer; but we put no limit above. They have had the right for all these years, and enjoy it now, of providing a salary adequate to command the entire time of a health-officer for the county; and we hope, in the near future, to see a number of the counties in my state availing themselves of their privilege, one county having already done so. The only obstacle is the lack of education of the people as to the need of such an officer and what he may do for them. I am glad to say that we are not confronted or surrounded by any of the difficulties mentioned by Dr. Perkins. We in Alabama, fortunately, are absolutely divorced from politics in our public-health administration. The election of health-officers is vested in the organized profession; the doctors, in their organized capacity, name every health-officer in Alabama, from the state health-officer down to a health-officer for the smallest municipality. Our people approve this feature of our system, and we have never had any difficulty in maintaining it. With us it is simply a question of the education of the people as to the need of full-time county health-officers.

DR. W. S. RANKIN, Raleigh, N. C.: Dr. Dublin called attention to the fact that our state had more full-time health-officers than any other state that he had replies from. We have eleven whole-time county health-officers in North Carolina. There

are 100 counties in the state. We could have had, if we had pushed our campaign along quantitative rather than qualitative lines, twenty or thirty counties. I believe what I say with regard to the counties of North Carolina would apply to the counties throughout the South. There is comparatively little difficulty in persuading a county to employ a whole-time man and to appropriate from $2,500 to $3,500 for the salary and expenses of such a health-officer, requiring him to own an automobile. Of course, a whole-time man with an automobile is worth two without one. To get whole-time health-officers in the counties is easy, and I will give our methods to anybody that wants them. After the officer is obtained, the troublesome thing is to get him to do the right kind of work. Dr. Dublin recommends that the state shall have power to require the whole-time officer to perform certain duties. That is about the only way that this system of county health-work will amount to anything. My first idea was, after the whole-time men were elected, to have them take three or four days to confer concerning their four or five definite fundamental duties; then for them to adopt some system of work embodying these duties. The report should be such that, when published by the state board of health, it would be comparative. I derived my idea from the work of the Rockefeller Commission in the South. Their men are all doing the same kind of work, making the same kind of report and using similar report blanks; at the end of each week the results are published in such a tabulation as to make a comparative showing for each man. Instead of statutory power to compel these men to do certain things, we simply wanted to use that powerful law-enforcing power in American life—the power of publicity—to make them do their duty. If we could have gotten them to adopt a uniform standard of work and a uniform monthly report, and then published the work of each man, each month, in the health bulletin distributed throughout the state, and in the newspapers, we would have had all the power that we needed.

When the whole-time men came together, however, they decided that, inasmuch as some of them were inexperienced in health-work and the whole thing was experimental, they had better not establish any uniform plan to begin with, but rather should spend six or eight or twelve months in the field and find what work was needed, then later, perhaps, adopt a uniform standard of work.

We are now having much trouble over some differences of opinion between the state and county authorities as to adopting the uniform standard of work and reports. The question will probably go to the general assembly sooner or later of giving the state board of health the right to define the duties of the county health-officer and prescribe the form of his report.

If we can say, "Here is the report form on which you must report your work each month," then publish that man's work in the newspapers of the state, it will eliminate the unfit county health-officers. Not only that, but when the work of the efficient man is published throughout the state, the other eighty-nine counties wanting health-officers will say: "Why, here is a man getting $2,500 and he is leading the work," or, "He is the second or third man. We think he is worth more than $2,500." They will give the man that really deserves it a salary he can live on.

DR. J. W. TRASK, Washington, D. C.: I think both Dr. Dublin's paper and its discussion show distinct progress in the evolution of health administration in this country. It is especially interesting, in my opinion, as showing the approach of the second step in health organization. I believe it is logical to assume that the state, being the larger unit of population and the larger political jurisdiction, will develop an efficient health department before the counties do. I take it that Dr. Dublin presupposes full-time state health-officers. Unfortunately, that is not so throughout all the country; but I do not believe that the development of the county organization should be delayed on that account. The position of state health-officer is not only one that requires an able man, but requires all his time. I do not believe that it is compatible with proper state health administration that the state health-officer should be devoting his attention to other things and his official work constitute a side line. Dr. Dublin's logic is sound, and, assuming that the necessity of full-time state health-officers has been established, it is time to strengthen health administration in the next smaller political subdivision of territory. It does not necessarily mean a county. I think that the county, however, having already a political organization, will in most instances be found the most suitable and convenient. The progress of health organization is undergoing a natural evolution. It was first appreciated that the state needed all the time of its health-officer. It is now apparent that the county also needs a full-time health-officer. In time further needs for full-time health-officials will undoubtedly be found in territorial subdivisions smaller than counties where the population is sufficiently great.

DR. S. A. KNOPF, New York: We have heard a good deal of the duties of the health-officers, but nothing of their rights. It seems to me that any health-officer without police power is but a feeble power in his community. I had occasion recently to examine some country schools, and, to my amazement, I found that the hygiene in those schools is sometimes many times worse than in cities. In many communities I have found that the health-officer has no control over the tuberculous patients who, because of ignorance or indifference, infect not only the members of their own families, but their close neighbors and

friends. If the health-officer of any community is not empowered to remove such dangerous patients to a place of safety, I mean where they will not be allowed to spread their disease, I cannot see the utility of the officer in relation to tuberculosis. Unless the health-officer can order an unsanitary school to be made sanitary, he is but a weak factor in his community. I highly approve of all Dr. Dublin's suggestions. I hope those in power will propose bills and help in the enactment of laws whereby the health-officer of any community, small or large, shall be given police power to enable him to enforce the sanitary regulations whereby the whole community is to benefit.

DR. A. T. MCCORMACK, Bowling Green, Ky.: I want to express my appreciation of Dr. Dublin's excellent work. I think nothing went further in showing the members of our recent general assembly the wisdom of legislation creating full-time health-officers than the publication which Dr. Dublin distributed in Kentucky. The value of such essays distributed to the people has been greatly emphasized in our state, and I am glad to express the gratitude Kentucky feels to the Rockefeller Sanitary Commission for the Eradication of Hookworm Disease for the opportunities it has given to the people of Kentucky to see actual demonstrations of what a full-time health-officer can do. The health campaigns which have been conducted in Kentucky in connection with this commission, this dispensary work, with a trained sanitary inspector in charge, with expert microscopists, with the trained workers in the warfare against tuberculosis conducting campaigns of from three weeks' to three months' duration in many counties, carrying the lessons of better health and longer life into the rural homes and country stores and schools and churches, are in this way best enabling the people themselves to realize what would be possible if each county could have a man devoting his entire time and energy to this work, assisted and supported, as he would be, by the organized medical profession and an educated public opinion. There was not an intelligent or thinking member of our recent legislature from a section in which these dispensaries had been held who was not only in favor of the creation of a full-time health-officer, but was more in favor of this legislation than any other matter before the general assembly. In Kentucky more than 200,000 men, women and children have been examined for intestinal parasites, and nearly half of them have been found to harbor hookworms or some other variety. If the Rockefeller Sanitary Commission had accomplished nothing else, if not one of those infected had been treated (and practically all of them were treated), the change of sentiment brought about by the demonstration to our people of the accurate sanitary methods of modern medicine, their increased confidence in their family physicians, their increased desire for better and more practical

education in preventive medicine, would have justified the expenditure of all the money and energy which has been put into the work.

L. I. DUBLIN, PH.D., New York: Dr. Rankin's experience should prove most valuable to every state health-officer. It seems to me like a hopeless task to begin with the idea of local autonomy, although there is always a great temptation to do that. As Dr. Rankin has pointed out, there is the strong possibility that a group of county health-officers will combine for selfish purposes and defy the state department to compel them to do the right thing under the law. Unless they are appointed subject to the approval of the state department and can be removed from office by the state department, the administration of the county health service is very likely to become political and of little value. I therefore hope most sincerely that the committee appointed to report a bill for full-time health-service will have in mind a system in which the state is the central authority, the several county officers being at all times responsible to the state and subject to its control. A bill which will have the approval of your organization and that of other national organizations like the American Public Health Association will have great weight with the state legislatures and is very likely to be enacted into law.

Permit me, also, to remark that should any state officer here present endeavor to introduce into his state a full-time county health-officer bill, approved by this association, if he will address the Metropolitan Life Insurance Company at its Home Office in New York, I can assure him of the helpful co-operation of that organization. The Welfare Department of that company will be ready to interest the field force and medical examiners in that state and will urge them to write to and see their representatives in the legislature. We have done this in a goodly number of states already, and have reason to believe that we have obtained good results. The Metropolitan Life Insurance Company is always ready to further approved legislation that means better health service.

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